

TARGET POPULATION: COMPLEX PATIENTS

Complex Patient Definition: Individuals who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the individual's overall health status.

Or

Individuals who need extra care due to complex medical issues that are often times compounded by social, economic, environmental, and behavioral factors. **[Alternative proposed for discussion]**

Program Description and Objective:

Description: The complex care management intervention will be person-centered and will target complex individuals to be connected to a comprehensive care team that is focused on identifying the individual's clinical and social needs, developing a plan to address those needs, and creating action steps so that the individual is both directing and involved in managing their care.

Person-Centered Definition: The individual self-determines and identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning. The individual actively makes all decisions about their care plan and treatment. Person-centered care focuses on the individual's values, belief, preferences, and needs, and ensures that these factors guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life.

Objective: In the short-term, comprehensively address the identified barriers to care and healthy living and engage the individual directly in their own self-care. In the long-term, provide the individual with the appropriate resources and skills to improve their self-determination and feeling of empowerment to do longer-term self-care management. This will be accomplished by providing person-centered comprehensive care management, care coordination, education and self-management support services, skills training, and necessary connections to community and social support services.

High-Level Program Design:

1. Identify complex individuals
2. Establish a comprehensive care team workforce
3. Connect individuals to the comprehensive care team
4. Conduct person-centered assessment
5. Develop a care coordination care plan
6. Execute and monitor the care coordination care plan
7. Identify when individual is ready to transition to self-directed care maintenance
8. Monitor individuals to reconnect to comprehensive care team when needed
9. Evaluate the effectiveness of the intervention

1. Identify complex individuals

- The network identifies complex individuals who will benefit from comprehensive care team support by using basic analytics to develop a risk stratification¹ methodology that takes into consideration utilization data (claims based), clinical, behavioral, and social determinant risks (EMR)²
- The network conducts a root cause analysis for the complex individual sub-population and identifies and implements at least one additional network capability to supplement the comprehensive care team intervention³
- The root cause analysis utilizes:
 - Relevant clinical data
 - Input from the complex individual sub-population⁴

2. The network establishes a comprehensive care team workforce

- The network develops a comprehensive care team that fulfills several functions⁵ including:
 - Case management
 - Clinically focused care coordination
 - Community focused care coordination to link individuals to needed social services and supports as well as culturally and linguistically aligned self-care management education.
 - The network includes a Community Health Worker⁶ on the comprehensive care team to fulfill the community focused function.
 - Oversight and management of the comprehensive care team
- The network provides timely access to or has a comprehensive care team member who is a licensed behavioral health specialist capable of a comprehensive behavioral health assessment⁷
- The network adds comprehensive care team members outside of the above core functions (i.e.; dietitians, pharmacists, etc.) on an as needed basis depending on the needs of their specific patient population
- The network determines the best strategy for incorporating the members of the comprehensive care team into the primary care practices. Options include:
 - Employ members of the comprehensive care team within each primary care practice
 - Employ members of the comprehensive care team at one or more hub in support of multiple practices
 - Contract with members of the comprehensive care team⁸

¹ See Appendix A for definition

² See Appendix B for examples of the type of criteria used in other models

³ The CCIP elective capability standards can serve as guidance to the networks, but should not limit the scope of possibilities

⁴ Input can be solicited in a number of ways, including, but not limited to a community advisory board, a focus group, existing community meetings or community leadership

⁵ The networks will have the freedom to determine which care team members best fulfill these functions with the exception of the CHW, and can utilize licensed or unlicensed individuals to fulfill these roles

⁶ See Appendix A for definition

⁷ See Appendix A for definition

⁸ Likely the only member of the comprehensive care team for which contracting would be an option is the community health worker

- The network establishes the appropriate case load (individuals to team ratio) for the comprehensive care team⁹
- The network establishes training protocols on:
 - Identifying values, principles and goals of the comprehensive care team intervention
 - Redesigning the primary care workflow to integrate the comprehensive care team work processes
 - Orienting the primary care team to the roles and responsibilities of the comprehensive care team members¹⁰
 - Basic behavioral health training appropriate for all comprehensive community care team members
 - Delivering culturally and linguistically appropriate services standards consistent with Department of Health and Human Services, Office of Minority Health, CLAS standards
- The network develops and administers CHW training protocols or ensures that CHWs have otherwise received such training:
 - Person-centered assessment support
 - Outreach methods and strategies
 - Effective communication methods
 - Health education for behavior change
 - Methods for supporting, advocating and coordinating care for individuals
 - Public health concepts and approaches
 - Community capacity building (i.e.; improving ability for communities to care for themselves) (Boston, 2007)
 - Safety training geared toward maintaining safety in the home
- The network ensures training is provided:
 - To all primary care team members involved in the comprehensive care team intervention
 - On an annual basis to incorporate new concepts and guidelines and reinforce initial training

3. Connect individuals to the comprehensive care team

- The network implements a process to connect individuals to the complex care management support. Options for interacting with the individual include:
 - During the primary care visit
 - During an ED visit or inpatient hospital stay¹¹

⁹ Optimal ratios should be determined by the network based on local needs

¹⁰ The PTF expressed that the network and its practices understanding of a Community Health Worker role is of particular importance as unlike other members of the care team their primary role is to support and coordinate care for the individual in the community, posing a significant departure from how care is more commonly delivered today

¹¹ Networks could consider utilizing an ED/Inpatient technology that alerts the comprehensive care team upon admission and discharge of eligible individuals

- Pro-actively reaching out to the individual¹²

4. Comprehensive care team conducts person-centered assessment¹³

- To understand the historical and current clinical, social and behavioral needs of the individual to inform the person-centered care coordination plan, the network conducts a person-centered needs assessment that includes¹⁴:
 - Preferred language
 - Family/social/cultural characteristics
 - Assessment of health literacy
 - Social determinant risks
 - Personal preferences, values, needs, and strengths
 - Assessment of behavioral health needs, inclusive of mental health, substance abuse, and trauma
 - The primary and secondary clinical diagnoses that are most challenging for the individual to manage
- Network defines process and protocols for the comprehensive care team to conduct the person-centered needs assessment that will include:
 - Defining where the person-centered needs assessment takes place¹⁵
 - Defining the timeframe within which the person-centered needs assessment is completed post-identification of individual need

5. Develop a person-centered care coordination plan¹⁶

- The comprehensive care team and the individual and their natural supports¹⁷ collaborate to develop a person-centered care coordination plan¹⁸ that reflects the person-centered needs assessment and includes the following features:
 - Incorporates the individual's preferences and lifestyle goals
 - Establishes behavioral goals to address existing mental health, substance abuse, or trauma needs
 - Establishes social health goals to address largest social determinant risk factors as identified by the individual
- The network defines a process and protocol and protocol for the comprehensive care team to create a person-centered care coordination plan including location and timeframe for completion

6. Execute and monitor care coordination plan

¹² Experience in other states suggest that the individual who is pro-actively reaching out to individuals should be someone they identify with and who can build rapport with them (e.g.; a peer support or CHW) (Center for Healthcare Solutions, 2015)

¹³ See Appendix A for definition

¹⁴ See Appendix B for an example of a needs assessment

¹⁵ The PTF believes this should be determined by the individual

¹⁶ See Appendix A for definition

¹⁷ Natural supports include but are not limited to, family, clergy, friends, and neighbors

¹⁸ See Appendix B for an examples of person-centered care coordination plans

- The network establishes protocols for regular comprehensive care team meetings that establish:
 - Who is required to attend¹⁹
 - The frequency of the meetings
 - The format of the meetings (i.e.; via conference call, in person, etc.)
 - A standardized reporting form on the individual's progress and risks
- The network establishes protocols for monitoring individual progress on the person-centered care coordination plan that includes:
 - Establishing key touch points for monitoring and readjusting of the person-centered care coordination plan, as necessary
 - Establishing who from the comprehensive care team will be involved in the touch points
 - Developing a standardized progress note that documents key information obtained during the touch points
- The network modifies its process for exchanging health information across care settings to accommodate the role and functions of the comprehensive care team²⁰
- The network develops a process and protocols for connecting individuals to needed community services (i.e.; social support services) which include:
 - See: Community and Clinical Integration Program Shared Governance Standards

7. Identify when individual is ready to transition to self-directed care maintenance

- The network collaborates with the individual to assess their readiness to independently self-manage²¹
- If desired by the individual, the network provides transitional support by connecting them to a Peer Support resource

8. Monitor individuals to reconnect to comprehensive community care team when needed

- The network establishes a mechanism to monitor transitioned individuals to notify the comprehensive care team when they are in crisis and need to be reconnected to the comprehensive care team²²

9. Evaluate the effectiveness of the intervention

- The network demonstrates that the comprehensive care team is improving health care outcomes and care experience for complex individuals by:
 - Tracking aggregate clinical outcome, individual care experience, and utilization measures that are relevant to the target population's needs (i.e.; complex individuals)²³

¹⁹ Best practice suggests all members of the comprehensive care team and relevant primary care team members

²⁰ This will include establishing the necessary agreements with providers with whom information will be exchanged, identifying the type of information to be exchanged, timeframes for exchanging information, and how the organization will facilitate referrals

²¹ See Appendix B for sample tool

²² The network could consider utilizing a ED/Inpatient admission/discharge alert technology for monitoring

²³ Clinical measure and experiences measures for complex individuals should be determined based on the most prevalent clinical areas of need for the network's complex individuals (e.g.; behavioral health) and lower performing experience measures; utilization measures will likely include inpatient admissions for ambulatory sensitive conditions, readmissions, and ED utilization

- Achieving improved performance on identified measures
- Identify opportunities for quality process improvement. This will require:
 - Defining process and outcome measures specific to the comprehensive care team intervention
 - Establishing a method to share performance²⁴ data regularly with comprehensive care team members and other relevant care providers to collectively identify areas of improvement

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²⁴ Performance is commonly shared through a dashboard or scorecard. Networks should also consider establishing learning collaboratives that bring together the different practices in their network to share best practices

Appendix A – Definitions

Community Health Worker: A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery (<https://www.apha.org/apha-communities/member-sections/community-health-workers>)

Comprehensive Behavioral Health Assessment: An assessment that screens for behavioral health, substance abuse, and trauma and is delivered by a licensed clinical professional

Person-Centered: The individual self-determines and identifies their natural supports, which may include but is not limited to family, clergy, friends and neighbors and chooses whether to involve them in their medical care planning. The individual actively makes all decisions about their care plan and treatment. Person-centered care focuses on the individual's values, belief, preferences, and needs, and ensures that these factors guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life.

Person-Centered Assessment: An assessment that will evaluate the person's historical and current needs while considering the individual's cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles

Person-Centered Care Coordination Plan: A care plan used by the comprehensive care team that is developed with consideration for the individual's cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles as well as their strengths.

Risk Stratification: The separation of a population into sub-populations based on a set of risk criteria. In this case the risk criteria being considered is around what makes an individual complex, as defined by the Practice Transformation Taskforce. The PTF definition of complex is: Individuals who have either multiple complex medical conditions, multiple detrimental social determinants of health, or a combination of both that contribute to preventable service utilization and poorer overall healthcare management that ultimately negatively impacts the Individual's overall health status.

Appendix B – Sample Tools

Complex Patient Criteria Examples:

Camden Coalition Care Management Triage (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-care-management-triage-current.pdf>)

Camden Coalition Pre-Enrollment Form – with risk stratification (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-pre-enrollment-bedside-intake.pdf>)

Needs Assessment Examples

Camden Coalition Care Management Enrollment Intake (<https://www.camdenhealth.org/wp-content/uploads/2012/10/Enrollment-Intake14July2014.pdf>)

Care Plan Examples

Camden Coalition Care Plan (<https://www.camdenhealth.org/cross-site-learning/resources/care-interventions/care-management-information/>)

Kansas Medicaid Health Home Action Plans
(http://www.kancare.ks.gov/health_home/providers_forms.htm)

Readiness to Transition to Self-Directed Care Examples:

The Client Perception of Care Questionnaire (CPCQ) (<https://www.camdenhealth.org/wp-content/uploads/2012/10/CCHP-CPCQ-for-pre-enrollment-and-graduation.pdf>)